GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-2440 [Telephone] (866) 888-7130 [Fax]
www.sos.state.ga.us/plb/counselors

PROFESSIONAL COUNSELOR
PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION – FORM A

INSTRUCTIONS: Please type or print clearly. **NO FAXED FORMS ACCEPTED**

APPLICANTS;

- Complete Part I and submit to your Practicum/Internship Supervisor. See Board Rule Chapter 135-5-.02(2)5.
- If you have more than one practicum or internship, submit a form for each. You may photocopy this form.

PRACTICUM/INTERNSHIP SUPERVISOR:

Complete Part II, noting requirements. Please enclose this form in a sealed envelope. Sign your name over the flap and then either mail it to the applicant or send it directly to the Board office. Fax copies are not acceptable.

The Practicum/Internship must:

- Be part of the master's degree program.
- Be in Professional Counseling or in Applied Psychology before January 1, 2004.
- Include a minimum of 300 hours in the practice of counseling under supervision.

The Practicum/Internship Supervisor must:

- **Be the Instructor of Record at the college or university or the Site Supervisor; and**
- Be licensed – as a Professional Counselor, Clinical Social Worker, Marriage and Family therapist, Psychologist, Psychiatrist – or be a Certified Rehabilitation Counselor. See Board Rule Chapter 135-5-1(a)5 for further details.

PART I – APPLICANT

NAME: _____

SOCIAL SECURITY NUMBER: _____

* This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

PART II – SUPERVISOR

NAME:

ADDRESS:_____
Street City State Zip Code

TELEPHONE: ( ) | FAX: ( )

TYPE OF LICENSE: ❒ Professional Counselor ❒ Clinical Social Worker ❒ Marriage and Family Therapist ❒ Psychologist ❒ Psychiatrist ❒ Certified Rehabilitation Counselor

LICENSE #:	STATE:	DATE ISSUED:	EXP. DATE:

CERTIFICATION OF SUPERVISION:

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced Professional Counseling work at:

NAME OF PRACTICUM/INTERNSHIP SITE: _____

FROM: _____ TO: _____ FOR A TOTAL OF _____ HOURS.
MONTH/YEAR MONTH/YEAR # HOURS

DESCRIBE THE PRACTICE SUPERVISED:

VERIFICATION: I attest that I provided the supervision described above and that this is a true and accurate representation of this supervision.

_____ _____
Date Signature of Supervisor/Instructor of Record

Sworn to and subscribed before me this
_____ day of _____, _____.

_____
Notary Public
My commission Expires: _____ NOTARY SEAL